FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0053488

Facility Name: Westside Rehab & Care Center

Address: 601 N Columbia St (Number) West Frankfort (City) 62896 (Zip Code)

County: Franklin

Telephone Number: (618) 932-2109 **Fax #** (618) 937-3289

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2009

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,254	7,530	2,561	21,345	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,254	7,530	2,561	21,345	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.92%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified ____ and days of care provided 2,373

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	114,222	6,982	3,946	125,150		125,150	7,214	132,364			1
2	Food Purchase		122,634		122,634		122,634	(3,759)	118,875			2
3	Housekeeping	64,496	16,085		80,581		80,581	44	80,625			3
4	Laundry	29,368	3,330		32,698		32,698		32,698			4
5	Heat and Other Utilities			61,031	61,031		61,031	271	61,302			5
6	Maintenance	33,780	8,180	13,297	55,257		55,257	2,712	57,969			6
7	Other (specify):* Home Off. Ben. All.											7
8	TOTAL General Services	241,866	157,211	78,274	477,351		477,351	6,482	483,833			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	26	12,026			9
10	Nursing and Medical Records	798,869	69,691	9,320	877,880		877,880	(244)	877,636			10
10a	Therapy		110	211,526	211,636		211,636		211,636			10a
11	Activities	35,253	174	268	35,695		35,695	(5,300)	30,395			11
12	Social Services	29,187			29,187		29,187		29,187			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	863,309	69,975	233,114	1,166,398		1,166,398	(5,518)	1,160,880			16
	C. General Administration											
17	Administrative			261,000	261,000		261,000	(201,833)	59,167			17
18	Directors Fees											18
19	Professional Services			5,499	5,499		5,499	8,832	14,331			19
20	Dues, Fees, Subscriptions & Promotions			3,059	3,059		3,059	50	3,109			20
21	Clerical & General Office Expenses	20,285	1,434	22,176	43,895		43,895	80,001	123,896			21
22	Employee Benefits & Payroll Taxes			165,363	165,363		165,363	17,025	182,388			22
23	Inservice Training & Education							33	33			23
24	Travel and Seminar							28	28			24
25	Other Admin. Staff Transportation			4,025	4,025		4,025	4,381	8,406			25
26	Insurance-Prop.Liab.Malpractice			32,326	32,326		32,326	632	32,958			26
27	Other (specify):* Home Off. Ben. All.											27
28	TOTAL General Administration	20,285	1,434	493,448	515,167		515,167	(90,851)	424,316			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,125,460	228,620	804,836	2,158,916		2,158,916	(89,887)	2,069,029			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Westside Rehab & Care Center #0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			26,804	26,804		26,804	60,111	86,915			30
31	Amortization of Pre-Op. & Org.							994	994			31
32	Interest			6,676	6,676		6,676	43,678	50,354			32
33	Real Estate Taxes			6,741	6,741		6,741	20,377	27,118			33
34	Rent-Facility & Grounds			66,035	66,035		66,035	(66,035)				34
35	Rent-Equipment & Vehicles			7,086	7,086		7,086	1,068	8,154			35
36	Other (specify):*											36
37	**TOTAL Ownership**			113,342	113,342		113,342	60,193	173,535			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,185		98,185		98,185		98,185			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,448	180,448		180,448		180,448			42
43	Other (specify):*		174	164,806	164,980		164,980	(164,980)				43
44	**TOTAL Special Cost Centers**		98,359	345,254	443,613		443,613	(164,980)	278,633			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,125,460	326,979	1,263,432	2,715,871		2,715,871	(194,674)	2,521,197			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,843)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,656)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,403)	30		9
10	Interest and Other Investment Income	(1,156)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(149)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(95,458)	43		18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,628)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(21,767)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (188,160)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,514)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (6,514)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (194,674)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Westside Rehab & Care Center

ID# 0053488

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (8,746)	43	1
2	X-Rays-Part A	(6,873)	43	2
3	Disallowed Special Events	(256)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(63)	21	4
5	Pet Expense	(114)	43	5
6	Offset Transportation Revenue	(5,300)	11	6
7	Disallowed Chamber of Commerce Dues	(150)	20	7
8	Offset Miscellaneous Nursing Supplies Revenue	(265)	10	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(21,767)		49

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 3,142	$ 3,142	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	75	75	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	16	16	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	212	212	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,192	1,192	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care, Inc.	100.00%	26	26	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	8
9	V	10A	TherUy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	2,710	2,710	12
13	V								13
14	Total			$			$ 7,374	$ * 7,374	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 151	$ 151	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,373	35,373	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,608	1,608	17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	18	18	18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	11	11	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,861	2,861	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	504	504	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,889	2,889	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	1,837	1,837	24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	142	142	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	727	727	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 46,121	$ * 46,121	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Petersen West Frankfort, LLC		$ 69,429	$ 69,429	15
16	V	32	Interest		Petersen West Frankfort, LLC		33,920	33,920	16
17	V	33	Real Estate Taxes		Petersen West Frankfort, LLC		20,125	20,125	17
18	V	34	Rent-Facility and Grounds	66,035	Petersen West Frankfort, LLC			(66,035)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 66,035			$ 123,474	$ * 57,439	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 4,072	$ 4,072	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	9	9	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	28	28	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	59	59	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,520	1,520	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	20	20	22
23	V	10A	TherUy		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	17	Administrative	261,000	Petersen Health Care Management, Inc.	100.00%	59,167	(201,833)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	6,122	6,122	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	$ 49	49	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	44,691	44,691	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	15,417	15,417	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	15	15	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	17	17	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,520	1,520	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	128	128	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	196	196	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	260	260	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	110	110	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	341	341	38
39	Total			$ 261,000			$ 133,741	$ * (127,259)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health & Wellness, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health & Wellness, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health & Wellness, LLC	100.00%	0		17
18	V	5	Utilities		Petersen Health & Wellness, LLC	100.00%	0		18
19	V	6	Maintenance		Petersen Health & Wellness, LLC	100.00%	0		19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		20
21	V	9	Medical Director		Petersen Health & Wellness, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health & Wellness, LLC	100.00%	0		22
23	V	10A	Therapy		Petersen Health & Wellness, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		24
25	V	17	Administrative		Petersen Health & Wellness, LLC	100.00%	0		25
26	V	19	Professional Services		Petersen Health & Wellness, LLC	100.00%	0		26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health & Wellness, LLC	100.00%	$ 0		27
28	V	21	Clerical and General Office		Petersen Health & Wellness, LLC	100.00%	0		28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health & Wellness, LLC	100.00%	0		29
30	V	23	Inservice Training & Education		Petersen Health & Wellness, LLC	100.00%	0		30
31	V	24	Travel and Seminar		Petersen Health & Wellness, LLC	100.00%	0		31
32	V	25	Other Admin. Staff Transport.		Petersen Health & Wellness, LLC	100.00%	0		32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health & Wellness, LLC	100.00%	0		33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		34
35	V	30	Depreciation		Petersen Health & Wellness, LLC	100.00%	0		35
36	V	31	Amortization of Pre-Op. & Org.		Petersen Health & Wellness, LLC	100.00%	994	994	36
37	V	32	Interest		Petersen Health & Wellness, LLC	100.00%	8,817	8,817	37
38	V	33	Real Estate Taxes		Petersen Health & Wellness, LLC	100.00%	0		38
39	Total			$			$ 9,811	$ * 9,811	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6	N/A										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,572,338	77	$ 231,473	$ 220,289	21,345	$ 3,142	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	21,345	75	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	21,345	16	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	21,345	212	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	21,345	1,192	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,345	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	21,345	26	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	21,345	1	8
9	10A	TherUy	Resident Days	1,572,338	77	0	0	21,345	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,345	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	21,345	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	21,345	2,710	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	21,345	151	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	21,345	35,373	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476	0	21,345	1,608	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	21,345	18	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	21,345	11	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	21,345	2,861	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	21,345	504	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,345	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	21,345	2,889	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	21,345	1,837	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	21,345	142	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	21,345	727	24
25	TOTALS					$ 3,940,617	$ 2,699,523		$ 53,495	25

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Management, Inc.
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,572,338	77	$ 299,961	$ 294,997	21,345	$ 4,072	1
2	2	Food	Resident Days	1,572,338	77	675		21,345	9	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	21,345	28	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		21,345	59	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	21,345	1,520	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,345		6
7	9	Medical Director	Resident Days	1,572,338	77			21,345		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		21,345	20	8
9	10A	TherUy	Resident Days	1,572,338	77			21,345		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,345		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	21,345	59,167	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		21,345	6,122	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		21,345	49	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	21,345	44,691	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	1,135,672		21,345	15,417	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		21,345	15	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		21,345	17	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		21,345	1,520	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		21,345	128	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,345		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		21,345	196	21
22	32	Interest	Resident Days	1,572,338	77	19,133		21,345	260	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		21,345	110	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		21,345	341	24
25	TOTALS					$ 10,069,824	$ 8,113,127		$ 133,741	25

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health & Wellness, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,572,338	11	$	$	21,345	$	1
2	2	Food	Resident Days	1,572,338	11			21,345		2
3	3	Housekeeping	Resident Days	1,572,338	11			21,345		3
4	5	Utilities	Resident Days	1,572,338	11			21,345		4
5	6	Maintenance	Resident Days	1,572,338	11			21,345		5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	11			21,345		6
7	9	Medical Director	Resident Days	1,572,338	11			21,345		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	11			21,345		8
9	10A	Therapy	Resident Days	1,572,338	11			21,345		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	11			21,345		10
11	17	Administrative	Resident Days	1,572,338	11			21,345		11
12	19	Professional Services	Resident Days	1,572,338	11			21,345		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	11			21,345		13
14	21	Clerical and General Office	Resident Days	1,572,338	11			21,345		14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	11			21,345		15
16	23	Inservice Training & Education	Resident Days	1,572,338	11			21,345		16
17	24	Travel and Seminar	Resident Days	1,572,338	11			21,345		17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	11			21,345		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	11			21,345		19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	11			21,345		20
21	30	Depreciation	Resident Days	1,572,338	11			21,345		21
22	31	Amortization of Pre-Op. & Org.	Resident Days	1,572,338	11	7,964		21,345	994	22
23	32	Interest	Resident Days	1,572,338	11	70,629		21,345	8,817	23
24	33	Real Estate Taxes	Resident Days	1,572,338	11			21,345		24
25	TOTALS					$ 78,593	$		$ 9,811	25

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	Varies	3/1/09	$ 1,312,500	$ 651,326	12/31/14	Varies	$ 40,596	1
2												2
3								Interest Income Offset			(1,156)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,312,500	$ 651,326			$ 39,440	9
	B. Non-Facility Related*											
10								Home Office Allocation-PHC			1,837	10
11								Home Office Allocation-PHCM			260	11
12								Home Office Allocation-PHW			8,817	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 10,914	14
15	TOTALS (line 9+line14)						$ 1,312,500	$ 651,326			$ 50,354	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 26,796	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013	$ 26,183	2
3. Under or (over) accrual (line 2 minus line 1).		$ (613)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 27,479	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** 252 **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 27,118	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	26,683	8
	2010	28,582	9
	2011	27,402	10
	2012	26,015	11
	2013	26,183	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westside Rehab & Care Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0053488

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-24-105-002	601 N. Columbia, West Frankfort, IL	$ 26,183.30	$ 26,183.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,183.30	$ 26,183.30

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,727 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 188,185 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 994 4. Dates Incurred: 2013-2014

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	17,241	2009	$ 180,000	1
2					2
3	TOTALS	17,241		$ 180,000	3

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96		2009	1979	$ 1,350,000	$	25	$ 54,000	$ 54,000	$ 297,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof Repair			2010	2,750		7	393	393	1,765	9
10	Call Cord Replacements			2014	10,481		15	233	233	233	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Land Improvements Booked								63
64	Building Booked			54,000			(54,000)		64
65	Building Improvement Booked			626			(626)		65
66									66
67	2014-Home Office Allocation-Building Improvements		9,964			239	239		67
68	2014-Home Office Allocation-Land Improvements		930			51	51		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,374,125	$ 54,626		$ 54,916	$ 290	$ 298,998	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 289,412	$ 41,345	$ 28,942	$ (12,403)	5-10 yrs.	$ 157,433	71
72	Current Year Purchases	15,103	262	262		10 yrs.	262	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,795	2,795			74
75	TOTALS	$ 304,515	$ 41,607	$ 31,999	$ (9,608)		$ 157,695	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,858,640	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 96,233	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,915	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,318)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 456,693	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 8,154 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Westside Rehab & Care Center
0053488
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	1,967
Dishwasher		659
Laundry Equipment		-
Copier		4,460
Home Office Allocation		1,068
		8,154

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	5,230	$ 78,448	$	5,230	$ 78,448	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,303	34,540		2,303	34,540	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,569	98,538	110	6,569	98,648	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				98,185		98,185	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	14,102	$ 211,526	$ 98,295	14,102	$ 309,821	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 117,359	$ 117,359	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 102,178)	375,477	375,477	3
4	Supply Inventory (priced at Cost)	6,808	6,808	4
5	Short-Term Investments			5
6	Prepaid Insurance	34,685	34,685	6
7	Other Prepaid Expenses	10,000	10,000	7
8	Accounts Receivable (owners or related parties)	(86,585)	(86,585)	8
9	Other(specify): Security Deposit	50	50	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 457,794	$ 457,794	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	180,000	180,000	13
14	Buildings, at Historical Cost	1,350,000	1,359,964	14
15	Leasehold Improvements, at Historical Cost	13,231	14,161	15
16	Equipment, at Historical Cost	304,515	304,515	16
17	Accumulated Depreciation (book methods)	(554,923)	(456,693)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,292,823	$ 1,401,947	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,750,617	$ 1,859,741	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 660,618	$ 660,618	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,958	70,958	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,615	17,615	31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,479	27,479	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	27,968	27,968	36
37	Accrued Management Fees	374,106	374,106	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,178,744	$ 1,178,744	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	651,326	651,326	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To Related Parties	556,185	556,185	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,207,511	$ 1,207,511	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,386,255	$ 2,386,255	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (635,638)	$ (526,514)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,750,617	$ 1,859,741	48

***(See instructions.)**

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (440,996)	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (440,998)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	226,736	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 226,736	17
	B. Transfers (Itemize):		
18	Transfer of Net Assets due to Corporate Restructuring	(421,376)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (421,376)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (635,638)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,670,497	1
2	Discounts and Allowances for all Levels	(326,782)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,343,715	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	413,380	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 413,380	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,843	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	148,876	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	20,915	20
21	Other Medical Services	5,094	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 178,728	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,156	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,156	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	5,628	28
28a	Transportation Revenue		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,628	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,942,607	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	477,351	31
32	Health Care	1,166,398	32
33	General Administration	515,167	33
	B. Capital Expense		
34	Ownership	113,342	34
	C. Ancillary Expense		
35	Special Cost Centers	263,165	35
36	Provider Participation Fee	180,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,715,871	40
41	**Income before Income Taxes (line 30 minus line 40)****	226,736	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 226,736	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,104,354	44
45	Private Pay - Net Inpatient Revenue	758,743	45
46	Medicare - Net Inpatient Revenue	453,389	46
47	Other-(specify) Insurance Net Allowance	28,864	47
48	Other-(specify) Charity and Insurance Contractual Allowance	(1,635)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,343,715	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 69,694	$ 33.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,500	4,608	90,538	19.65	3
4	Licensed Practical Nurses	14,330	14,685	248,647	16.93	4
5	CNAs & Orderlies	38,676	38,229	350,533	9.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,663	1,700	17,002	10.00	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	29,187	14.03	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	20,466	9.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,513	10,912	93,756	8.59	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	33,780	16.24	17
18	Housekeepers	7,194	7,467	64,496	8.64	18
19	Laundry	3,325	3,392	29,368	8.66	19
20	Administrator	2,080	2,080	59,167	28.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,425	1,500	20,285	13.52	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	3,780	3,879	57,708	14.88	33
34	TOTAL (lines 1 - 33)	95,806	96,772	$ 1,184,627 *	$ 12.24	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	79	$ 3,946	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,125	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	79	$ 18,071		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Westside Rehab & Care Center
0053488
Period Beginning **1/1/2014**
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Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,080	2,080	39,457	18.97
Transportation	1,700	1,799	18,251	10.15
TOTAL	3,780	3,879	57,708	

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chris Ely	Administrator	0	$ 59,167
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,167

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 261,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 261,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Honkamp Kruger & Co.	Accounting Fees	$ 1,533
Mediacom	Computer Services	1,551
E-Health Data Solutions	Computer Services	2,221
Franklin County Clerk	Filing Fees	140
Franklin County Sheriff	Filing Fees	54
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 5,499

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,426
Unemployment Compensation Insurance	43,688
FICA Taxes	76,181
Employee Health Insurance	(1,965)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,033
Home Office Allocation	17,025
TOTAL (agree to Schedule V, line 22, col.8)	$ 182,388

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 54.5	545
Miscellaneous Licenses & Permits	308
Miscellaneous Dues & Subscriptions	216
Home Office Allocation	200
Less: Public Relations Expense	(150)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,109

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	28
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28

**See instructions.

Westside Rehab & Care Center
0053488
Period Beginning **1/1/2014**
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,499
Home Office Allocation		
Lexis Nexis	Legal	7
GoffWilson	Legal	497
Illinois Secretary of State	Legal	45
Bank of America	Legal	150
Healthcare Resources International	Legal	90
Miscellaneous	Legal	19
Addy, Bush	Legal	13
Hall, Rustom, and Fritz	Legal	15
Black, Hedin, Ballard	Legal	26
SmithAmundsen	Legal	26
CliftonLarson Allen	Accountants	1,058
Ginoli & Co.	Accountants	970
Miscellaneous	Computer Services	20
Odessian LLC	Computer Services	6
Optimizer	Computer Services	42
Allpayer Exchange	Computer Services	13
CCH	Computer Services	22
Prism Software	Computer Services	68
Macquarie Technology Services	Computer Services	59
Advanced Answers on Demand	Computer Services	3,135
Stratus Networks	Computer Services	413
Kemper Technology	Computer Services	1,223
AT&T	Computer Services	5
Ability Network	Computer Services	474
Barracuda	Computer Services	108

CIAN	Computer Services	129
Comcast	Computer Services	33
Emdeon	Computer Services	84
Charter Communications	Computer Services	5
Crawford County Title Co.	Other Prof Fees	6
Better Banks	Other Prof Fees	4
David Budde	Other Prof Fees	36
All Scripts	Other Prof Fees	25
Total (agree to Schedule V, line 19, column 8)		14,325

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,179** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **180,448**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,843**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **5,300**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adqequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.